

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149

Primary Registration District No. 1002 Registrar's No. 6557

**63-048177**  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED DEC 19 1963

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in 1b <u>40 YEARS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>GENERAL HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>1663 SUMMIT STREET</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLYDE</u> Middle <u>R.</u> Last <u>NADERHOFF</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>1</u> Year <u>1963</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/5/1885</u>
9. AGE (last birthday) <u>78</u>		10. IF UNDER 1 YEAR Months <u>78</u> Days <u>6</u> Hours <u>8</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CABINET MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CITY RECREATION</u>	
11. BIRTHPLACE (City and state or country) <u>UNKNOWN, ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>UNKNOWN NADERHOFF</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
14. NAME OF HUSBAND OR WIFE <u>JESSIE M. NADERHOFF</u>		Address <u>3027 FOLTON, BERKELEY CALIF.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WORLD WAR I</u>		16. SPECIAL CERTIFICATE NO. <u>MRS. MURIEL BEATTY ROSENKRANZ</u>	
17. INFORMANT <u>MRS. MURIEL BEATTY ROSENKRANZ</u>		Address <u>3027 FOLTON, BERKELEY CALIF.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Fell down stairs</u>	
20c. TIME OF INJURY Hour <u>11-2363</u> a.m. p.m. Month, Day, Year	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Bedroom</u>		
20e. CITY, TOWN, OR LOCATION <u>Kansas City</u>		COUNTY <u>JACKSON</u> STATE <u>MO</u>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>7:55 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Wm. H. Owens</u>		22b. ADDRESS <u>152 Union Station</u>	
22c. DATE SIGNED <u>12-3-63</u>		22d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>	
23a. NAME OF CEMETERY OR CREMATORY <u>D.W. NEWCOMER'S SONS</u>		23b. DATE <u>DEC. 4 1963</u>	
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS, K.C., MO.</u>		25. DATE RECD. BY LOCAL REG. <u>12-4-63</u>	
26. REGISTRAR'S SIGNATURE <u>Beaie Smith</u>			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 28 1964

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert J. Bayen

Licensed Embalmer No. 4892

P. O. Address Overland Park, KS

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.